HIV/AIDS Education Project

2006 Iowa

School Health Profiles

Prepared for:
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Bureau of Instructional Services

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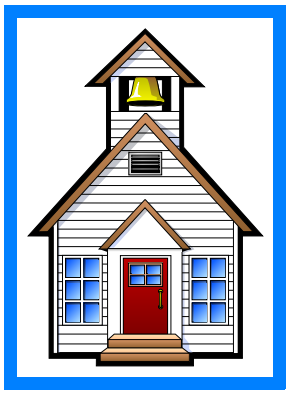

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Introduction

The Iowa Department of Education HIV/AIDS Education Program, through a cooperative agreement with the Division of Adolescent and School Health (DASH), National Center for Chronic Disease Prevention and Health Promotion, U.S. Centers for Disease Control and Prevention (CDC), provides assistance to schools and other youth service agencies to strengthen comprehensive school health education to prevent human immunodeficiency virus (HIV) infection and other sexually transmitted diseases (STDs), and to promote healthy behaviors and attitudes. Program requirements include the monitoring (at least every two years) of the number and percentage of schools that provide education to prevent health risk behaviors as part of a comprehensive school health program.

2006 Iowa SHP: Instruments, Samples, and Reporting

The School Health Profiles include two questionnaires, one for school principals and one for lead health education teachers. (The questionnaires are presented in the Appendix.) The principal's questionnaire was used to provide data on policies and programs related to health education and services, physical education/activity, tobacco-use prevention, violence prevention, nutrition, and HIV infection. The health education teacher's questionnaire provided data on school health education, HIV prevention, collaboration, staff development, and professional preparation. *The overall results are presented for the entire sample when the percentages are more or less homogeneous; otherwise, results are presented for (1) middle school, (2) junior/senior high school, and (3) senior high school, defined in Table 1 below.*

Table 1: Definitions of grade categories

Grade Category	Low Grade Criterion	High Grade Criterion
Middle school	-[a]	9 or lower
Junior/senior high school	8 or lower	10 or higher
Senior high school	9 or higher	10 or higher

[a] The "-" indicates no single low grade criterion was used for this grade category. However, middle schools traditionally serve grades 6 through 8 (or sometimes 9).

The questionnaires were developed by the DASH/CDC in collaboration with representatives of 75 state, local, and territorial departments of education. They were mailed to 354 secondary schools containing any of the grades 6 through 12 in Iowa during the spring of 2006. Useable survey data were obtained from 273 principals and 275 teachers.

The data are reported in summarized form. For a more detailed summary of the data, see the document *2006 School Health Profiles Report: Iowa Department of Education* (Centers for Disease Control and Prevention, 2006). In addition to detailed tables with point and interval estimates, this report includes graphics that can be used to produce overhead transparencies for use in presentations. Additional transparencies or a slide show will be developed for presenting the Iowa SHP results as needed. An administrative summary is also available for more general dissemination. This document contains the basic information regarding methodology and highlights of the results. Finally, this report and the administrative summary will be posted on the Iowa Department of Education Web site (**www.state.ia.us/educate**) in portable document format for electronic access.

Overview: Comprehensive School Health Education in Iowa

Effective comprehensive school health education programs focus on reducing behaviors that place youth at risk for serious health problems. This includes reducing sexual behaviors that can lead to HIV infection, other sexually transmitted diseases (STDs), and unintended pregnancies. Other risky behaviors include tobacco use, alcohol and other drug use, improper nutrition, sedentary lifestyles, intentional and unintentional injuries, and violent activity.

The CDC's definition of a comprehensive school health education program includes the following:

- a documented, planned, sequential program of health education for students in grades K through 12;
- a curriculum that addresses and integrates education about a range of categorical health problems and issues (e.g., HIV infection, drug abuse, drinking and driving, emotional health, environmental pollution) at developmentally appropriate ages;
- activities to help young people develop the skills they will need to avoid: (a) behaviors that result in intentional and unintentional injuries; (b) drug and alcohol abuse; (c) tobacco use; (d) sexual behaviors that result in HIV infection, other STDs, and unintended pregnancies; (e) imprudent dietary patterns; and (f) inadequate physical activity;
- instruction provided for a prescribed amount of time at each grade level;
- management and coordination in each school by an education professional trained to implement the program;
- instruction from teachers who have been trained to the subject;
- involvement of parents, health professionals, and other concerned community members;
- periodic evaluation, updating, and improvement.

HIV prevention education is an important component of a comprehensive school health education program. The above definition distinguishes between (1) skills-based HIV education and comprehensive school health education and (2) HIV/AIDS awareness presentations and non-comprehensive health courses. In Iowa, HIV policy evaluations provided direction for both policymaking process and content, including HIV education policy, addressing the needs of persons infected with HIV, and infection control procedures (Veale, 1994 and 2005). In addition, needs assessments have been conducted with elementary and secondary schools, and postsecondary teacher preparation programs to determine the training and educational needs for Iowa educators and students in HIV prevention (Veale, 2000, 2001, 2002, and 2004).

Regarding health education needs assessment from the student's perspective, the 2007 Iowa Youth Risk Behavior Survey is currently being conducted. It is being administered to a sample of high schools in Iowa (including alternative schools) to assess the level of involvement in risky behaviors for students in these schools. Assuming sufficient response rates for weighting the data, we will be able to make statements concerning the level of such behavior among all

high school students in Iowa in 2007, as well as changes in this level of behavior over the past decade (Veale, 2006a and 2006b). The YRBS provides an important complement to the SHP in that it provides *student* input regarding their health and risk thereto. *Together, these surveys, conducted in alternate years, provide a comprehensive picture of the health of Iowa students of today—their risky as well as more positive behaviors and education programs and policies that should impact those behaviors*.

Methodology

The 2006 School Health Profiles (SHP) consisted of two questionnaires—one for school principals and the other for lead health education teachers (LHETs). The survey for principals consisted of questions about health and HIV education from an administrative perspective, while the survey for LHETs examined health and HIV education from an instructional standpoint. The surveys were developed cooperatively by the CDC and 75 agencies including state departments of education, as well as local and territorial education units in the United States to monitor the current status of school health education, including education to prevent HIV infection, STDs, and other important health problems that occur at the middle, junior high, and senior high school levels. The 2006 School Health Profiles consisted of 45 questions for the school principals and 21 questions for the lead health education teachers. The rationale for the questions included in the 2006 SHP is presented in the supplementary document *2006 School Health Profiles Report: Iowa Department of Education* (Centers for Disease Control and Prevention, 2006). A few changes were made to the 2004 SHP.

Sampling Procedure

Schools were selected using systematic equal probability sampling with a random start. The principal and lead health education teacher (LHET) were surveyed at each participating school. Prior to sampling, the schools were sorted by estimated enrollment in the target grades within the school grade level (e.g., middle school). This increased the likelihood of securing a sample that was representative of the population—at least with respect to estimated enrollment. This process was repeated for each targeted school grade level.

A sample size of 354 was determined from finite sampling theory for proportions, using a 5% margin of error with 95% confidence (e.g., Cochran, 1963), assuming a response rate of 75%.[1] This represented slightly more than 50% of the number of schools (722) in the population of middle, junior/senior high, and senior high schools in Iowa. Westat, Inc. selected the sample of 354 from a sampling frame consisting of all 722 schools. Six (6) of the 354 sampled schools were determined to be ineligible, so the effective sample size was 348 schools.

The superintendents and principals in the schools sampled were then contacted. A cover letter was sent to each, along with a copy of both the principal and LHET surveys. The principal was asked to select one teacher to complete the LHET survey in the school. This was to have been someone who was in charge of health education in the school.

Usable data were received from 273 out of the 348 sampled principals from the eligible schools. This yielded a response rate for the school principal questionnaire of 78.4%. Usable data were received from 275 out of 348 sampled lead health education teachers from the eligible schools. This yielded a response rate for the LHET questionnaire of 79.0%. Both of these response rates were judged sufficient by the CDC for making inferences about the populations.[2] In fact, these rates exceeded the projected rate of 75%, so the sample sizes were somewhat larger than those required for the established margin of error (5%) and level of confidence (95%).

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[1] The following formula was used: $ME = t\,(1 - n/N)^{1/2}\,[pq/(n - 1)]^{1/2} + 1/2n$, where "ME" is the margin of error, "t" is the value of the standard normal deviate, "N" is the population (sampling frame) size, "p" is the true value of the proportion responding in a particular way to the question, and $q = 1 - p$. Here, we set ME = .05 (5%), t = 1.96, N = 722, and $p = q = 0.5$. The value of 265 for "n" was obtained by iteration ("trial and error"). It was conservatively estimated that the response rate would be (at least) 0.75 or 75%. Inflating the "n" by this anticipated (minimum) response rate yielded n = 265/0.75, or 354 (rounding up).

[2] With random systematic sampling as delineated in this section, a minimum of 70% response is required by the CDC for making inferences about the population based on these profiles.

The breakdown by school grade level is presented in Table 2 (Jennifer Kali, personal communication, February 2007). These sample sizes should be considered on questions where breakdowns over school grade levels are needed. Moreover, on particular questions, the sample sizes may be even smaller due to selective nonresponse. The statistical effect of such breakdowns is wider confidence intervals. Thus, we feel that overall results using the total sample (yielding shorter confidence intervals) should be used, with specific grade level results presented only when they are of particular interest.

Table 2: Sample size breakdown by school grade level

Survey	Number in Middle School Sample	Number in Junior/Senior High Sample	Number in Senior High Sample	Total Sample Size
Principal	92 (33.7%)	72 (26.4%)	109 (39.9%)	273
LHET	94 (34.2%)	70 (25.5%)	111 (40.4%)	275
Population	287 (40.1%)	119 (16.6%)	310 (43.3%)	716

Note: Some of the percentages may not add to 100% due to rounding error.

Note the lack of agreement between the percentages in the sample (for both the principal and LHET surveys) and those of the population. Exact chi-square goodness-of-fit tests using *StatXact 6* (Cytel Statistical Software) showed significant differences between the population and (a) the principals' sample grade level data ($p = .000$) and (b) the LHETs' sample grade level data ($p = .000$). However, note the excellent agreement between the principal and LHET grade level data ($p = .970$). According to Westat, the population (frame) and sample differences were due to (1) differences in the grade span (grade levels) indicated by principals and teachers in their schools and how it was defined in the population frame and (2) differences in the levels of nonresponse in the three grade level categories. This effect of differences in the grade span (survey versus frame) was greater than the effect of nonresponse. This was primarily due to principals and teachers identifying relatively fewer middle and high schools and more junior/senior high schools in the sample than in the frame. Either the grade spans for these schools were incorrectly identified in the frame or the principals *and* teachers incorrectly identified them (to the same degree). The nonresponse was adjusted for in the weighting of the survey responses, discussed in the next section, and in the resulting point and interval estimates. The differences in grade span/levels in the population frame versus the principal and LHET samples was not adjusted for and constitutes a limitation regarding the results of the profiles (Jennifer Kali, personal communication, February 2007).

Weighting the Survey Responses

A "weight" has been associated with each questionnaire to reflect the likelihood of a principal or LHET being selected, to reduce bias by compensating for differing patterns of nonresponse, and to improve precision by making school sample distributions conform to known population distributions. The weight used for estimation of population parameters is given by

$$W = W_1 \times f_1 \times f_2$$

where

W_1 = 1/(probability of school selection);

f_1 = a nonresponse adjustment factor calculated by school size (large, medium, and small) and school grade level (middle school, junior/senior high, high school);

f_2 = a poststratification adjustment factor calculated by type of locale (large central city, mid-size central city, urban fringe of large city, urban fringe of mid-size city, large town, small town, rural metropolitan statistical area (MSA), rural non-MSA) and school grade level (middle school, junior/senior high, high school).

Thereby, the data were adjusted somewhat to reflect differences in the number of population units that each case represented. This is somewhat similar to what is done, for example, in stratified sampling. A weighted mean or percentage was computed for each item on the survey. (The actual process of weighting is rather complicated and was conducted by Westat, Inc. using specialized statistical software.)

Data Analysis

The primary focus in data analysis is on the estimation of population parameters, namely the proportion of principals or lead health education teachers with the various health education attributes assessed in the questionnaires. These analyses were conducted by Westat, Inc., a contractor for the CDC. In addition to point estimates, 95% confidence intervals were computed. These statistics were used to make inferences concerning the health policy and education attributes of principals and lead health education teachers *in all regular secondary public schools in Iowa having at least one of the grades 6 through 12.*

Informal tests of statistical significance using the confidence intervals for the three grade levels (middle school, junior/senior high, and senior high school) were conducted on data from a few selected survey questions to assess the differences in the results by school grade level. Confidence intervals that did not overlap provided evidence of statistically significant differences. Since these intervals were computed by taking into account the differential weighting of the responses based on the sampling scheme (and nonresponse patterns), this method was recommended over classical methods for simple random sampling such as Pearson chi-square (Mary Nixon, Westat statistician, personal communication, December 5, 1996). For example, question 2 on the principal's survey regarding whether health education is required yielded the three confidence intervals represented in Figure 1. The fact that these confidence intervals do not *all* overlap (middle school interval does not overlap with either of the other two), indicated that the results for this question differed by school grade level. In others, e.g., question 44 regarding whether or not the school has a policy on students and/or staff who have HIV infection or AIDS, all of the confidence intervals overlapped. No differences over grade levels were indicated on this question.[3]

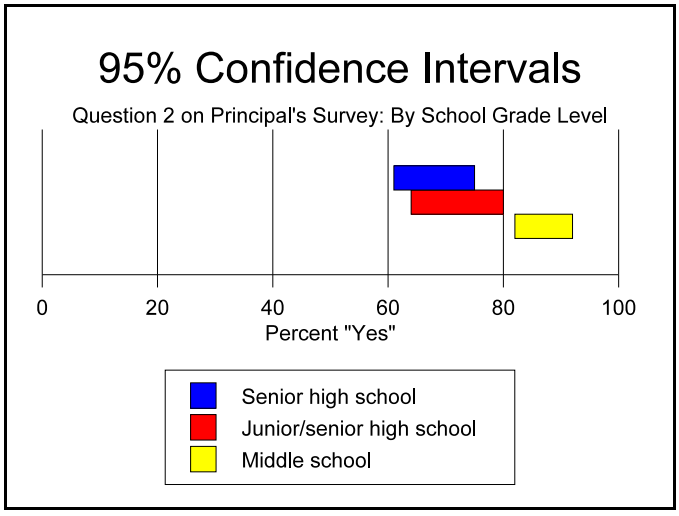

Figure 1: Non-overlapping confidence intervals on question 2 of principal's survey (evidence of statistically significant differences among school grade levels).

[3] Differences in responses to the same questions used in surveys administered over time (e.g., the 2004 and 2006 SHPs) are handled somewhat differently. The confidence interval approach for such differences is somewhat problematic, due to the possibility of repeated (non-independent) measurement among some of the respondents. In this report, only results where such differences were "substantial" (based on author judgement) were cited.

We always report the overall results for the total sample. Such data are meaningful even if differences exist over some of the grade levels, since the random sample was taken over the entire state. In selected questions, where significant differences are detected, the grade level results provide additional information for more specific recommendations for health education.

The point and interval estimates are presented in a supplementary report for all survey items on each of the two questionnaires using data from respondents at each of the three school grade levels, as well as the combined sample. The item question, choices, sample size ("n"), and raw counts are also presented for each item, as well as graphical representations for use in presentations. These data summaries were produced by Westat, Inc. and are provided in the document *2006 School Health Profiles Report: Iowa Department of Education* (Centers for Disease Control and Prevention, 2006).

Summary Methods

The data are reported here in summarized form. This includes the percentages responding "Yes" (or selecting a particular choice) for binary coded questions, and the percentages for the most frequently selected response choice(s) in questions with three or more possible choices. The percentages for middle, junior/senior high, and/or senior high school are presented for selected questions. In addition, comparisons are made with results from earlier profiles (e.g., the 2004 SHP) for selected questions.

2006 Iowa School Health Profiles:

Results of the School Principal Survey

The overall results of the 2006 Iowa SHP based on the school principal survey are presented below for secondary schools. Point estimates (in percent) are provided along with the number of responses on which these percentages were based. In selected questions, grade level breakdowns or comparisons with results from the 2004 (or earlier) profiles are provided if significant or substantial differences were indicated.

Eligibility Question

Question 1: Are any of the following grades taught in this school? (Grades 6-12 were given as choices.)

This question was asked to determine eligibility for the survey. There were considerable differences over grade level categories as one might expect. (For the data on this question, see the document *2006 School Health Profiles Report: Iowa Department of Education* (Centers for Disease Control and Prevention, 2006).) No responding school was determined to be ineligible.

Required Health Education

Question 2: Is health education required for students in any of grades 6 through 12 in this school?

Based on 271 responses, it is estimated that 76% of secondary principals indicated that health education was required for students in one or more of grades 6 through 12.

There were significant differences between middle school and (1) junior/senior high school principals and (2) senior high school principals on this question ($P < .05$). The percentage responding "Yes" varied from 87% in middle schools and 72% in junior/senior high schools to 68% in senior high schools. A higher percentage of middle school principals indicated that health education was required in their schools than did junior/senior high school and senior high school principals. (Recall Figure 1 and the discussion on p. 6.)

Question 3: Is required health education taught in each of the following ways to students in grades 6 through 12 in this school? (Mark yes or no for each method.)

a. In a combined health education and physical education course

b. In a course mainly about another subject other than health education such as science, social studies, or English

Based on 191 responses, 41% of secondary principals indicated required health education was taught in a combined health education and physical education course. Based on 189 responses, 32% indicated it was taught mainly in a course about another subject (e.g., science, social studies, or English).

Question 4: How many required health education courses do students take in grades 6 through 12? (Mark one response.)

Based on 193 school principal responses, 44% indicated students took one course, 28% indicated students took two courses, 17% said students took three courses, and 5% indicated four or more courses were taken.

Question 5: Is a required health education course taught in each of the following grades in this school? (Mark yes, no, or not applicable for each grade.)

Based on between 86 and 125 responses, the overall percentage responding in the affirmative ranged from 68% in grades 7 and 8 to 29% in Grade 11 and just 25% in Grade 12.

Question 6: If students fail a required health education course, are they required to repeat it?

Based on 181 responses (those schools that required health education for students and where students take one or more health education courses in any of grades 6-12), 56% responded in the affirmative. These percentages varied from 16% in middle school to 71% in junior/senior high schools and 93% in senior high schools.

Question 7: Who coordinates health education in this school? (Mark one response.)

Overall, based on 264 principals responding to this question, 44% indicated the health education teacher coordinated health education in their school, followed by the district health education or curriculum coordinator with 19%.

Question 8: Are newly hired staff who teach health topics required to be certified, licensed, or endorsed by the state in health education?

Based on 267 responses, 76% of principals responded in the affirmative.

Question 9: Is there one or more than one group (e.g., a school health council, committee, or team) at this school that offers guidance on the development of policies or coordinates activities on health topics?

Based on 267 responses, 60% of principals responded in the affirmative to this question.

Required Physical Education and Physical Activity Programs

Question 10: Is physical education required for students in any of grades 6 through 12 in this school?

Based on 270 responses, 94% of principals responded in the affirmative to this question.

Question 11: How many required physical education courses do students take in grades 6 through 12 in this school? (Mark one response.)

Based on 244 responses, the most frequently selected responses were 2-3 courses and 6-7 courses (29%). Middle school principals frequently selected 2-3 courses, while junior/senior high school principals most frequently selected 6-7 courses. Ninety-one percent (91%) indicated they required 2 or more such courses.

Question 12: Is a required physical education course taught in each of the following grades in this school? (Mark yes, no, or not applicable for each grade.)

Among principals who indicated that their schools required physical education for students in *any* of grades 6-12, at least 97% indicated that it was required in *each* of grades 6-12. (These percentages were based on from 109 for 6th grade to 161 for 10th through 12th grade.)

Question 13: Can students be exempted from taking a required physical education course for one grading period or longer for any of the following reasons? (Mark yes or no for each reason.)

a. Enrollment in other courses (i.e., math or science)

b. Participation in school sports

c. Participation in other school activities (i.e., ROTC, band, or chorus)

d. Participation in community sports activities

e. Religious reasons

f. Long-term physical or medical disability

g. Cognitive disability

h. High physical fitness competency test score

i. Participation in vocational training

j. Participation in community service activities

Based on 244 responses, 79% indicated students may be exempted from physical education because of long-term physical/medical disability; based on 238 responses, 54% indicated students may be exempted for religious reasons; based on 243 responses, 40% indicated students may be exempted for enrollment in other courses.

Question 14: If students fail a required physical education course, are they required to repeat it?

Based on 244 responses, 62% responded in the affirmative to this question. However, this ranged from 15% among middle schools, to 86% in junior/senior high and 93% in high schools.

Question 15: Are newly hired staff who teach physical education required to be certified, licensed, or endorsed by the state in physical education?

Based on 272 responses, 96% responded in the affirmative to this question.

Question 16: Does this school offer students opportunities to participate in intramural activities or physical activity clubs?

Based on 272 responses, 45% responded in the affirmative to this question.

Question 17: Does this school provide transportation home for students who participate in after-school intramural activities or physical activity clubs?

Among schools indicating they offered students opportunities to participate in before- or after-school activities or physical activity clubs, based on 120 responses, only 32% responded in the affirmative to this question. This varied from 17% among high schools to 45% among middle schools.

Question 18: Outside of school hours or when school is not in session, do children or adolescents use any of this school's physical activity or athletic facilities for community-sponsored sports teams, classes, or lessons?

Based on 270 responses, 90% responded in the affirmative to this question.

Question 19: Does your school support or promote walking or biking to and from school (e.g., through promotional activities, designating safe routes or preferred routes, or having storage facilities for bicycles and helmets)?

Based on 272 responses, 53% responded in the affirmative to this question.

Tobacco Prevention Policies

Question 20: Has this school adopted a policy prohibiting tobacco use?

Based on 271 responses to this question, nearly all (98%) of the secondary school principals responded affirmatively to this question.

Question 21: Does the tobacco-use prevention policy specifically prohibit use of each type of tobacco for each of the following groups? (Mark yes or no for each type of tobacco for each group.)

a. Cigarettes

b. Smokeless tobacco (i.e., chewing tobacco, snuff, or dip)

c. Cigars

d. Pipes

The groups included (1) students, (2) faculty/staff, and (3) visitors.

Based on 257-259 responses, the percent affirming that their policies prohibited the use of various types of tobacco listed was 95-97% for students, 84-89% for faculty/staff, and 72-84% for school visitors.

Question 22: Does the tobacco-use prevention policy specifically prohibit tobacco use during each of the following times for each of the following groups? (Mark yes or no for each time for each group.)

a. During school hours

b. During non-school hours

As in the previous question, the groups included (1) students, (2) faculty/staff, and (3) visitors.

Based on 254 to 259 responses, the percent indicating their policies prohibited tobacco use for students was 99% during school hours and 94% during non-school hours; for faculty/staff, 86% during school hours and 61% during non-school hours; for visitors, 83% during school hours and 60% during non-school hours.

Question 23: Does the tobacco-use prevention policy specifically prohibit tobacco use in each of the following locations for each of the following groups? (Mark yes or no for each location for each group.)

Location

a. In school buildings

b. Outside on school grounds, including parking lots and playing fields

c. In school buses or other vehicles used to transport students

d. At off-campus, school-sponsored events

As in the previous questions, the groups included (1) students, (2) faculty/staff, and (3) visitors.

Based on 258 to 259 responses regarding the various locations, nearly all principals (99-100%) responded that smoking was specifically prohibited therein for students. Based on 255 to 257 responses, regarding the locations "In school buildings" and "In school buses ... ," 96% and 93% (respectively) affirmed that smoking was specifically prohibited in those areas for faculty/staff, while for locations "Outside on school grounds ..." and "At off-campus, school-sponsored events" 74% and 68% (respectively) indicated that smoking was specifically prohibited for faculty/staff. Based on 252 to 257 responses, regarding the "In school buildings" and "In school buses ... ," 96% and 91% (respectively) indicated that smoking was specifically prohibited for visitors, while for locations "Outside on school grounds ..." and "At off-campus, school-sponsored events" just 64% and 41% (respectively) indicated that smoking was specifically prohibited for visitors.

Question 24: Does your school have procedures to inform each of the following groups about the tobacco-use prevention policy that prohibits their use of tobacco? (Mark yes, no, or not applicable for each group.)

As in the previous questions, the groups included (1) students, (2) faculty/staff, and (3) visitors.

Based on 250 to 258 responses, 100% of principals indicated their schools had procedures to inform students about the tobacco prevention policy prohibiting use of tobacco, 95% indicated they had procedures to inform faculty/staff about the tobacco prevention policy prohibiting use of tobacco, and 78% indicated they had procedures to inform visitors about the tobacco prevention policy prohibiting use of tobacco.

Question 25: Does your school have procedures to inform students' families about rules related to tobacco use by students?

Based on 257 responses, 98% of the principals responded in the affirmative on this question.

Question 26: When students are caught smoking cigarettes, how often are each of the following actions taken? (Mark one response for each action.)

Action

a. Parents or guardians are informed

Based on the 258 principals responding to this question regarding this action, 98% indicated parents or guardians were always or almost always informed.

b. Referred to a school counselor

Based on the 255 principals responding to this question regarding this action, 43% indicated students were sometimes referred to a counselor and 35% indicated they were always or almost always so referred.

c. Referred to a school administrator

Based on the 256 principals responding to this question regarding this action, 99% indicated students were always or almost always so referred.

d. Encouraged, but not required to participate in an assistance, education, or cessation program

Based on the 256 principals responding to this question regarding this action, the highest percentage (43%) indicated students were sometimes encouraged to participate in such a program.

e. Required to participate in an assistance, education, or cessation program

Based on the 253 principals responding to this question regarding this action, 32% indicated students were never required to participate in such a program and 29% indicated they were rarely so required, while 30% indicated they were sometimes required to do so.

f. Referred to legal authorities

Based on the 253 principals responding to this question regarding this action, 41% indicated students were always or almost always referred to legal authorities and 39% indicated they were sometimes so referred.

g. Placed in detention

Based on the 256 principals responding to this question regarding this action, about 39% indicated students were never or rarely placed in detention (if caught smoking cigarettes), while 29% indicated they were sometimes detained and 32% indicated they were always or almost always detained.

h. Not allowed to participate in extra-curricular activities or interscholastic sports

Based on the 256 principals responding to this question regarding this action, 85% indicated students were always or almost always not allowed to participate in such activities or sports.

i. Given in-school suspension

Based on the 256 principals responding to this question regarding this action, 40% indicated students were sometimes given in-school suspension and 37% indicated they were always or almost always given such suspension.

j. Suspended from school

Based on the 251 principals responding to this question regarding this action, 36% indicated students were sometimes suspended from school and 32% indicated they were always or almost always suspended therefrom.

k. Expelled from school

Based on the 257 principals responding to this question regarding this action, 70% indicated students were never and 25% indicated they were rarely expelled from school.

l. Reassigned to an alternative school

Based on the 256 principals responding to this question regarding this action, 69% indicated students were never and 28% indicated they were rarely reassigned to an alternative school.

Question 27: Does your school provide referrals to tobacco cessation programs for each of the following groups? (Mark yes or no for each group.)

The groups were (a) faculty and staff and (b) students.

Based on the 270 principals responding to part (a) of this question, 17% indicated that faculty and staff would be referred to tobacco cessation programs. Based on the 269 principals responding to part (b), 48% indicated that students would be so referred (if caught using tobacco).

Question 28: Is tobacco advertising prohibited in each of the following locations? (Mark yes or no for each location.)

Location:

a. In the school building

Based on 272 principals responding to this part of the question, 95% indicated tobacco advertising was prohibited in the school building.

b. On school grounds including on the outside of the building, on playing fields, or other areas of the campus

Based on 272 principals responding to this part of the question, 94% indicated tobacco advertising was prohibited on the school grounds.

c. On school buses or other vehicles used to transport students

Based on 272 principals responding to this part of the question, 94% indicated tobacco advertising was prohibited on school buses or other student transportation vehicles.

d. In school publications (e.g., newsletters, newspapers, web sites, or other school publications)

Based on 272 principals responding to this part of the question, 94% indicated tobacco advertising was prohibited in school publications.

Question 29: Is tobacco advertising through sponsorship of school events prohibited?

Based on 272 principals responding to this question, 92% indicated tobacco advertising though sponsorship of school events was prohibited.

Question 30: Are students at your school prohibited from wearing tobacco brand-name apparel or carrying merchandise with tobacco company names, logos, or cartoon characters on it?

Based on 272 principals responding to this question, 97% indicated students were prohibited from wearing tobacco brand-name apparel or carrying such merchandise.

Question 31: Does your school post signs marking a tobacco-free school zone, that is, a specified distance from school grounds where tobacco use is not allowed?

Based on 270 principals responding to this question, 60% indicated their school posted signs marking a tobacco-free school zone. This was an increase in the percentage of school principals indicating they posted such signs over that reported in the 2004 SHP (52%), the 2002 SHP (46%), and the 2000 SHP (28%).

Nutrition-Related Policies and Practices

Question 32: How long do students usually have to eat lunch once they are seated? (Mark one response.)

a. Less than 20 minutes

b. 20 minutes or more

c. This school does not serve lunch to students

Based on 266 principals responding to this question, 33% indicated students had less than 20 minutes, while 67% said they had 20 minutes or more to eat lunch once seated.

Question 33: Does this school or district have a policy stating that, if food is served at student parties, after-school or extended day programs, or concession stands, fruits or vegetables will be among the foods offered?

Based on 271 principals responding to this question, only 12% indicated they had such a policy.

Question 34: Can student purchase snack foods or beverages from one or more vending machines at the school or at the school store, canteen, or snack bar?

Based on 267 principals, 88% responded in the affirmative to this question.

Question 35: Can students purchase each snack food or beverage from vending machines or at the school store, canteen, or snack bar? (Mark yes or no for each food or beverage.)

Food/Beverage

a. Chocolate candy

b. Other kinds of candy

c. Salty snacks that are *not* low in fat, such as regular potato chips

d. Salty snacks that *are* low in fat, such as pretzels, baked chips, or other low-fat chips

e. Fruits or vegetables, not juice

f. Low-fat cookies, crackers, cakes, pastries, or other low-fat baked goods

g. Soda pop or fruit drinks that are not 100% juice

h. Sports drinks

i. 100% fruit juice or vegetable juice

j. Bottled water

k. 1% or skim milk

l. 2% or whole milk (plain or flavored)

Among those schools where students can purchase snack foods/beverages, based on 227 to 230 responses, a little over half indicated chocolate candy was available, a little over 60% indicated other kinds of candy was available, 55% indicated salty snacks that are *not* low in fat and 66% indicated that those that *are* low in fat were available, 56% indicated low-fat cookies and other backed goods were available, and 83-98% indicated that the various types of beverages listed (other than milk) were available. Fifty (50) percent indicated that 1% or skim milk was available, while a little over 50% indicated that 2% or whole milk was available for purchase. Only 32% indicated that fruits or vegetables (other than juice) were available for purchase at their school.

Question 36: Can students purchase candy; snacks that are not low in fat; soda pop, sports drinks, or fruit drinks that are not 100% juice; or 2% or whole milk during the following times? (Mark yes or no for each time.)

Time

a. Before classes begin in the morning

b. During any school hours when meals are not being served

c. During school lunch periods

Among those schools where students can purchase snack foods/beverages, based on about 227 to 229 principals responding to this question, the percentage indicating students could purchase snack foods/beverages was (a) 68% before classes begin in the morning, (b) 51% during any school hours when meals are not being served, and (c) 41% during school lunch periods.

Violence Prevention

Question 37: Has your school ever used the School Health Index from the Centers for Disease Control and Prevention to assess your school's health and safety policies and programs?

Based on 260 principals responding to this question, only 16% responded affirmatively.

Question 38: Does your school implement each of the following safety and security measures? (Mark yes or no for each measure.)

Measure

a. Require visitors to report to the main office or reception area upon arrival

Based on 268 principals responding to this part of the question, 98% indicated visitors were so required.

b. Maintain a "closed campus" where students are not allowed to leave school during the day, including during lunch

Based on 267 principals responding to this part of the question, 76% indicated a closed campus was maintained in their schools.

c. Use staff or adult volunteers to monitor school halls during and between classes

Based on 267 principals responding to this part of the question, 87% indicated they used staff or adult volunteers to monitor their school halls.

d. Routinely conduct locker searches

Based on 268 principals responding to this part of the question, 40% indicated they routinely conducted such checks.

e. Require students to wear school uniforms

Based on 268 principals responding to this part of the question, just 1% indicated their students were required to wear school uniforms.

f. Require students to wear identification badges

Based on 268 principals responding to this part of the question, 2% indicated their students were required to wear identification badges.

g. Use metal detectors, including wands

Based on 268 principals responding to this part of the question, just 1% indicated metal detectors were used in their schools.

h. Use security or surveillance cameras, either inside or outside the building

Based on 268 principals responding to this part of the question, 35% indicated they used such cameras, either inside or outside the school building.

i. Use police, school resource officers, or security guards during the regular school day

Based on 268 principals responding to this part of the question, 24% indicated they used police, school resource officers, or security guards during the regular school day.

Question 39: Does your school have or participate in each of the following programs? (Mark yes or no for each program.)

Program

a. A peer mediation program

Based on 268 principals responding to this part of the question, 28% indicated they had or participated in a peer mediation program.

b. A safe-passages to school program

Based on 268 principals responding to this part of the question, 3% indicated they had or participated in a safe-passages to school program.

c. A program to prevent gang violence

Based on 268 principals responding to this part of the question, 12% indicated they had or participated in a program to prevent gang violence.

d. A program to prevent bullying

Based on 268 principals responding to this part of the question, 62% indicated they had or participated in a program to prevent bullying. This indicated a substantial increase in such programs from the 2004 SHP (47%).

Question 40: Does your school have a comprehensive plan to address crisis preparedness, response, and recovery in the event of a natural disaster or other emergency or crisis situation?

Based on 267 principals responding to this question, 97% indicated they had such a plan.

Health Services

Question 41: Is there a school nurse who provides standard health services to students at this school?

Based on 268 principals responding to this question, 86% indicated they had a school nurse.

Question 42: At this school, would a student ever be permitted to carry and self-administer each of the following medications? (Mark yes or no for each medication.)

Medication

a. A prescription quick-relief inhaler

Based on 271 principals responding to this question, 81% indicated they would be permitted this medication.

b. An epinephrine auto-injector (e.g., EpiPen®)

Based on 267 principals responding to this question, 45% indicated they would be permitted this medication.

c. Insulin or other injected medications

Based on 271 principals responding to this question, 27% indicated they would be permitted this medication.

d. Any other prescribed medications

Based on 269 principals responding to this question, 12% indicated they would be permitted any other prescribed medications.

e. Any over-the-counter medications

Based on 270 principals responding to this question, 25% indicated they would be permitted any over-the-counter medications.

Question 43: Does your school provide each of the following health services to students at this school? (Mark yes or no for each activity.)

Activity

a. Identification or school-based management of chronic health conditions, such as asthma or diabetes

Based on 271 principals responding to this part of the question, 75% indicated they provided this service.

b. Identification or school-based management of acute illnesses

Based on 268 principals responding to this part of the question, 67% indicated they provided this service.

c. An Asthma Action Plan (or Individualized Health Plan) for all students with asthma

Based on 267 principals responding to this part of the question, 58% indicated they utilized such a plan.

d. Immunizations

Based on 271 principals responding to this part of the question, 51% indicated they provided immunizations.

e. Assistance with enrolling in Medicaid or SCHIP (State Children's Health Insurance Program)

Based on 267 principals responding to this part of the question, 66% indicated they provided such assistance.

HIV Infection Policies

Question 44: Has this school adopted a policy on students and/or staff who have HIV infection or AIDS?

Based on 269 principals responding to this question, 43% indicated they had a policy on students or staff living with HIV or AIDS. This is down from 58% (for a somewhat more specific question) in the 2004 SHP.

Question 45: Does that policy address each of the following issues for students and/or staff with HIV infection or AIDS? (Mark yes or no for each issue.)

Issue

a. Attendance of students with HIV infection or AIDS

Among those who had adopted such a policy, based on 111 principals responding to this part of the question, 95% indicated they addressed the issue of attendance of these students in the policy.

b. Procedures to protect HIV-infected students and staff from discrimination

Among those who had adopted such a policy, based on 111 principals responding to this part of the question, 94% indicated they addressed the issue of procedures to protect these students and staff from discrimination in the policy.

c. Maintaining confidentiality of HIV-infected students and staff

Among those who had adopted such a policy, based on 111 principals responding to this part of the question, 95% indicated they addressed the issue of maintaining confidentiality of these students and staff in the policy.

d. Worksite safety (i.e., universal precautions for all school staff)

Among those who had adopted such a policy, based on 111 principals responding to this part of the question, 97% indicated they addressed the issue of worksite safety in the policy.

e. Confidential counseling for HIV-infected students

Among those who had adopted such a policy, based on 109 principals responding to this part of the question, 73% indicated they addressed the issue of confidential counseling for these students in the policy.

f. Communication of the policy to students, school staff, and parents

Among those who had adopted such a policy, based on 111 principals responding to this part of the question, 85% indicated they addressed the issue of communication of the policy to students, school staff, and parents.

g. Adequate training about HIV infection for school staff

Among those who had adopted such a policy, based on 111 principals responding to this part of the question, 91% indicated they addressed the issue of training about HIV infection for school staff in the policy.

h. Procedures for implementing the policy

Among those who had adopted such a policy, based on 111 principals responding to this part of the question, 93% indicated they addressed the issue of procedures for implementing the policy.

2006 Iowa School Health Profiles:

Results of the Lead Health Education Teacher Survey

The results of the 2006 Iowa SHP based on the lead health education teacher (LHET) survey are presented below. Point estimates (in percent) are provided along with the number of responses on which these percentages were based. In selected questions, grade level breakdowns or comparisons with results from the 2004 (or earlier) profiles are provided if significant or substantial differences were indicated.

Required Health Education Courses

Question 1: Is a health education course required for students in any of grades 6 through 12 in this school? (Mark one response.)

This question was used only as a "filter" for questions 2-11. That is, the results for those questions are based on data from LHETs answering "yes" to this question.

Question 2: Are teachers in this school required to use each of the following materials in a required health education course for student in grades 6 through 12? (Mark yes or no for each type of material.)

Materials

a. The National Health Education Standards

Based on 193 responses to this part of the question, 45% of LHETs indicated that the National Health Education Standards were required to be used in required health education courses.

b. The Health Education Curriculum Analysis Tool (HECAT) from the Centers for Disease Control and Prevention

Based on 191 responses to this part of the question, 6% of LHETs indicated that HECAT was required to be used in required health education courses.

c. Any state-, district-, or school-developed curriculum

Based on 192 responses to this part of the question, 82% of LHETs indicated that their state-, district-, or school-developed materials were required to be used in required health education courses.

d. A commercially-developed curriculum

Based on 193 responses to this part of the question, 27% of LHETs indicated that a commercially-developed curriculum was required to be used in required health education courses.

e. A commercially-developed student textbook

Based on 194 responses to this part of the question, 48% of LHETs indicated that a commercially-developed textbook was required to be used in required health education courses.

f. A commercially-developed teacher's guide

Based on 192 responses to this part of the question, 41% of LHETs indicated that a commercially-developed teacher's guide was required to be used in required health education courses.

g. Health education performance assessment materials

Based on 189 responses to this part of the question, 34% of LHETs indicated that such assessment materials were required to be used in required health education courses.

h. Any materials from health organizations, such as the American Heart Association or the American Cancer Society

Based on 194 responses to this part of the question, 36% of LHETs indicated that such materials from health organizations were required to be used in required health education courses.

Question 3: During this school year, have teachers in this school tried to increase student knowledge on each of the following topics in a required health education course in any of grades 6 through 12? (Mark yes or no for each topic.)

Topic

a. Alcohol or other drug use prevention

Based on 200 responses to this part of the question, 99% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of alcohol or other drug use prevention.

b. Asthma awareness

Based on 196 responses to this part of the question, 53% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of asthma awareness.

c. Consumer health, such as choosing sources of health-related information, products, and services wisely

Based on 198 responses to this part of the question, 89% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of consumer health.

d. Cardiopulmonary resuscitation (CPR)

Based on 198 responses to this part of the question, 61% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of CPR.

e. Dental and oral health

Based on 197 responses to this part of the question, 71% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of dental and oral health.

f. Emotional and mental health

Based on 199 responses to this part of the question, 96% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of emotional and mental health.

g. Environmental health, such as how air and water quality can affect health

Based on 198 responses to this part of the question, 72% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of environmental health.

h. First aid

Based on 199 responses to this part of the question, 70% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of first aid.

i. Foodborne illness prevention

Based on 197 responses to this part of the question, 72% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of foodborne illness prevention.

j. Growth and development

Based on 198 responses to this part of the question, 89% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of growth and development.

k. HIV (Human Immunodeficiency virus) prevention

Based on 196 responses to this part of the question, 96% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of HIV prevention.

l. Human sexuality

Based on 198 responses to this part of the question, 87% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of human sexuality.

m. Immunizations

Based on 197 responses to this part of the question, 61% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of immunizations.

n. Injury prevention and safety

Based on 198 responses to this part of the question, 82% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of injury prevention and safety.

o. Nutrition and dietary behavior

Based on 194 responses to this part of the question, 98% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of nutrition and dietary behavior.

p. Physical activity and fitness

Based on 192 responses to this part of the question, 99% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of physical activity and fitness.

q. Pregnancy prevention

Based on 179 responses to this part of the question, 94% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of pregnancy prevention.

r. STD (sexually transmitted disease) prevention

Based on 200 responses to this part of the question, 93% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of STD prevention.

s. Suicide prevention

Based on 198 responses to this part of the question, 78% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of suicide prevention.

t. Sun safety or skin cancer prevention

Based on 198 responses to this part of the question, 84% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of sun safety or skin cancer prevention.

u. Tobacco-use prevention

Based on 194 responses to this part of the question, 99% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of tobacco-use prevention.

v. Violence prevention (such as bullying, fighting, or homicide)

Based on 199 responses to this part of the question, 82% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of violence prevention.

Question 4: During this school year, have teachers in this school tried to improve each of the following student skills in a required health education course in any of grades 6 through 12? (Mark yes or no for each skill.)

Skill

a. How to find valid information or services related to personal health and wellness

Based on 200 responses to this part of the question, 86% of LHETs indicated that they tried to improve student skills in how to find valid health/wellness information or services, in required health education courses.

b. Influence of media on personal health and wellness

Based on 200 responses to this part of the question, 89% of LHETs indicated that they tried to improve student skills in analyzing the influence of media, in required health education courses.

c. Communication skills, such as how to ask for assistance with a health-related problem

Based on 200 responses to this part of the question, 83% of LHETs indicated that they tried to improve student communication skills, in required health education courses.

d. Decision-making skills, such as deciding to get appropriate health screenings and exams

Based on 198 responses to this part of the question, 84% of LHETs indicated that they tried to improve student decision-making skills, in required health education courses.

e. Goal-setting skills, such as setting a goal for improving personal health habits

Based on 200 responses to this part of the question, 92% of LHETs indicated that they tried to improve student goal setting skills, in required health education courses.

f. Conflict resolution skills, such as techniques to resolve interpersonal conflicts without fighting

Based on 200 responses to this part of the question, 84% of LHETs indicated that they tried to improve student conflict resolution skills, in required health education courses.

g. Resisting peer pressure to engage in unhealthy behavior related to personal health and wellness

Based on 200 responses to this part of the question, 96% of LHETs indicated that they tried to improve student skills in resisting peer pressure, in required health education courses.

Question 5: During this school year, how often have teachers in this school used each of the following teaching methods in a required health education course in any of grades 6 through 12? (Mark never, rarely, sometimes, or almost always or always for each teaching method.)[4]

Teaching method

a. Audio-visual media, such as videos

Based on 200 responses to this part of the question, 88% of LHETs indicated that they sometimes, almost always, or always used audio-visual media in required health education courses.

b. Group discussions

Based on 200 responses to this part of the question, 96% of LHETs indicated that they sometimes, almost always, or always used group discussions in required health education courses.

c. Cooperative group activities

Based on 200 responses to this part of the question, 91% of LHETs indicated that they sometimes, almost always, or always used cooperative group activities in required health education courses.

d. Role play, simulations, or practice

[4] The actual directions were incorrectly stated as "Mark yes or no for each teaching method."

Based on 199 responses to this part of the question, 63% of LHETs indicated that they sometimes, almost always, or always used role play, simulations, or practice in required health education courses.

e. Language, performing, or visual arts

Based on 196 responses to this part of the question, 46% of LHETs indicated that they sometimes, almost always, or always used language, performing, or visual arts in required health education courses.

f. Pledges or contracts for changing behavior or abstaining from a behavior

Based on 199 responses to this part of the question, 25% of LHETs indicated that they sometimes, almost always, or always used pledges or contracts for behavior change in required health education courses.

g. Peer teaching

Based on 199 responses to this part of the question, 62% of LHETs indicated that they sometimes, almost always, or always used peer educators in required health education courses.

h. The Internet

Based on 198 responses to this part of the question, 78% of LHETs indicated that they sometimes, almost always, or always used the Internet in required health education courses.

i. Computer-assisted instruction

Based on 193 responses to this part of the question, 50% of LHETs indicated that they sometimes, almost always, or always used computer-assisted instruction in required health education courses.

j. Guest speakers

Based on 197 responses to this part of the question, 60% of LHETs indicated that they sometimes, almost always, or always used guest speakers in required health education courses.

k. Health education programs available through videoconferencing or other distance learning methods

Based on 199 responses to this part of the question, 11% of LHETs indicated that they sometimes, almost always, or always used health education programs via videoconferencing/distance learning in required health education courses.

Question 6: During this school year, have teachers in this school used each of the following teaching methods to highlight diversity or the values of various cultures in a required health education course in any of grades 6 through 12? (Mark yes or no for each teaching method.)

Teaching method

a. Use textbooks or curricular materials reflective of various cultures

Based on 200 responses to this part of the question, 71% of LHETs indicated that they used textbooks or curricular materials reflective of various cultures to highlight diversity or the values of various cultures in a required health education course.

b. Use textbooks or curricular materials designed for students with limited English proficiency

Based on 198 responses to this part of the question, 24% of LHETs indicated that they used textbooks or curricular materials designed for students with limited English proficiency to highlight diversity or the values of various cultures in a required health education course.

c. Ask students to share their own cultural experiences related to health topics

Based on 198 responses to this part of the question, 58% of LHETs indicated that they asked students to share their own cultural experiences related to health topics to highlight diversity or the values of various cultures in a required health education course.

d. Teach about cultural differences and similarities

Based on 200 responses to this part of the question, 77% of LHETs indicated that they taught about cultural differences and similarities to highlight diversity or the values of various cultures in a required health education course.

e. Modify teaching methods to match students' learning styles, health beliefs, or cultural values

Based on 200 responses to this part of the question, 89% of LHETs indicated that they modified teaching methods to match students' learning styles, health beliefs, or cultural values to highlight diversity or the values of various cultures in a required health education course.

Question 7: During this school year, have teachers in this school asked students to participate in each of the following activities as part of a required health education course in any of grades 6 through 12? (Mark yes or no for each activity.)

Activity

a. Perform volunteer work at a hospital, a local health department, or any other local organization that addresses health issues

Based on 200 responses to this part of the question, 15% of LHETs indicated that they asked students to perform volunteer work in an organization that addresses health issues as part of a required health education course.

b. Participate in or attend a community health fair

Based on 198 responses to this part of the question, 12% of LHETs indicated that they asked students to participate in or attend a school or community health fair as part of a required health education course.

c. Gather information about health services that are available in the community, such as health screenings

Based on 200 responses to this part of the question, 39% of LHETs indicated that they asked students to gather information about health services that are available in the community as part of a required health education course.

d. Visit a store to compare prices of health products

Based on 200 responses to this part of the question, 17% of LHETs indicated that they had students visit a store to compare prices of health products as part of a required health education course.

e. Identify potential injury sites at school, home, or in the community

Based on 200 responses to this part of the question, 49% of LHETs indicated that they asked students to identify potential injury sites at school, home, or in the community as part of a required health education course.

f. Identify advertising in the community designed to influence health behaviors

Based on 200 responses to this part of the question, 61% of LHETs indicated that they asked students to identify advertising in the community designed to influence health behaviors as part of a required health education course.

g. Advocate for a health-related issue

Based on 199 responses to this part of the question, 44% of LHETs indicated that they asked students to advocate for a health-related issue as part of a required health education course.

h. Complete homework or projects that involve family members

Based on 199 responses to this part of the question, 77% of LHETs indicated that they had students complete homework assignments/projects that involved family members as part of a required health education course.

Question 8: During this school year, did teachers in this school teach each of the following tobacco-use prevention topics in a required health education course for students in any of grades 6 through 12? (Mark yes or no for each topic.)

Topic

a. Short- and long-term health consequences of cigarette smoking (such as stained teeth, bad breath, heart disease, and cancer)

Based on 194 responses to this part of the question, 99% of LHETs indicated that they taught the short-term and long-term health consequences of cigarette smoking as part of a required health education course.

b. Benefits of *not* smoking cigarettes (including long- and short-term health benefits, social benefits, environmental benefits, and financial benefits)

Based on 194 responses to this part of the question, 98% of LHETs indicated that they taught the benefits of not smoking cigarettes as part of a required health education course.

c. Short- and long-term health consequences of cigar smoking

Based on 199 responses to this part of the question, 77% of LHETs indicated that they taught the consequences of cigar smoking as part of a required health education course.

d. Short- and long-term health consequences of using smokeless tobacco

Based on 198 responses to this part of the question, 91% of LHETs indicated that they taught the short- and long-term health consequences of using smokeless tobacco as part of a required health education course.

e. Benefits of *not* using smokeless tobacco

Based on 198 responses to this part of the question, 91% of LHETs indicated that they taught the benefits of not using smokeless tobacco as part of a required health education course.

f. Addictive effects of nicotine in tobacco products

Based on 196 responses to this part of the question, 96% of LHETs indicated that they taught the addictive effects of nicotine in tobacco products as part of a required health education course.

g. How many young people use tobacco

Based on 199 responses to this part of the question, 91% of LHETs indicated that they taught how many young people use tobacco as part of a required health education course.

h. Influence of families on tobacco use

Based on 197 responses to this part of the question, 90% of LHETs indicated that they taught the influence of families on tobacco use as part of a required health education course.

i. Influence of the media on tobacco use

Based on 196 responses to this part of the question, 92% of LHETs indicated that they taught the influence of the media on tobacco use as part of a required health education course.

j. Social or cultural influences on tobacco use

Based on 197 responses to this part of the question, 88% of LHETs indicated that they taught the social or cultural influences on tobacco use as part of a required health education course.

k. How to find valid information or services related to tobacco-use prevention or cessation

Based on 199 responses to this part of the question, 79% of LHETs indicated that they taught how to find valid information or services related to tobacco use prevention/cessation as part of a required health education course.

l. Making a personal commitment not to use tobacco

Based on 197 responses to this part of the question, 69% of LHETs indicated that they taught the importance of making a personal commitment not to use tobacco as part of a required health education course.

m. How students can influence or support others to prevent tobacco use

Based on 193 responses to this part of the question, 88% of LHETs indicated that they taught how students can influence or support others to prevent tobacco use as part of a required health education course.

n. How students can influence or support others in efforts to quit using tobacco

Based on 197 responses to this part of the question, 85% of LHETs indicated that they taught how students can influence or support others in efforts to quit using tobacco as part of a required health education course.

o. Resisting peer pressure to use tobacco

Based on 195 responses to this part of the question, 93% of LHETs indicated that they taught how to resist peer pressure to use tobacco as part of a required health education course.

p. The health effects of environmental tobacco smoke (ETS) or second-hand smoke

Based on 197 responses to this part of the question, 94% of LHETs indicated that they taught the health effects of environmental tobacco smoke (ETS) or second-hand smoke as part of a required health education course.

A summary measure for this question on tobacco-use prevention topics is the percentage responding "yes" on all parts a-p. Based on 187 responding to all parts, 53% of LHETs indicated they taught *all* of these prevention topics.

Question 9: During this school year, did teachers in this school teach each of the following pregnancy, HIV, or STD prevention topics in a required health education course for students in any of grades 6 through 12? (Mark yes or no for each topic.)

Topic

a. Abstinence as the most effective method to avoid pregnancy, HIV (infection), and STDs

Based on 180 responses to this part of the question, 92% of LHETs indicated that they taught abstinence as the most effective method to avoid pregnancy, HIV infection, and STDs as part of a required health education course.

b. How to correctly use a condom

Based on 193 responses to this part of the question, 38% of LHETs indicated that they taught how to correctly use a condom as part of a required health education course.

c. Condom efficacy, that is, how well condoms work and do not work

Based on 187 responses to this part of the question, 75% of LHETs indicated that they taught condom efficacy as part of a required health education course.

d. Risks associated with having multiple sexual partners

Based on 178 responses to this part of the question, 90% of LHETs indicated that they taught risks associated with multiple sexual partners as part of a required health education course.

e. Social or cultural influences on sexual behavior

Based on 182 responses to this part of the question, 81% of LHETs indicated that they taught social or cultural influences on sexual behavior as part of a required health education course.

f. How to prevent HIV infection

Based on 178 responses to this part of the question, 92% of LHETs indicated that they taught how to prevent HIV infection as part of a required health education course.

g. How HIV is transmitted

Based on 178 responses to this part of the question, 93% of LHETs indicated that they taught how HIV is transmitted as part of a required health education course.

h. How HIV affects the human body

Based on 178 responses to this part of the question, 92% of LHETs indicated that they taught how HIV affects the human body as part of a required health education course.

i. Influence of alcohol and other drugs on HIV-related risk behaviors

Based on 182 responses to this part of the question, 87% of LHETs indicated that they taught the influence of alcohol and other drugs on HIV-related risk behaviors as part of a required health education course.

j. How to find valid information or services related to HIV or HIV testing

Based on 187 responses to this part of the question, 71% of LHETs indicated that they taught how to find valid information or services related to HIV or HIV testing as part of a required health education course.

k. Compassion for persons living with HIV or AIDS

Based on 184 responses to this part of the question, 74% of LHETs indicated that they taught compassion for persons living with HIV or AIDS as part of a required health education course.

A summary measure for this question on pregnancy, HIV infection, and STD prevention topics is the percentage responding "yes" on all parts a-k. Based on 175 responding to all parts, 35% of LHETs indicated they taught *all* of these prevention topics.

Question 10: During this school year, did teachers in this school teach each of the following nutrition and dietary topics in a required health education course for students in any of grades 6 through 12? (Mark yes or no for each topic.)

Topic

a. The benefits of healthy eating

Based on 195 responses to this part of the question, 96% of LHETs indicated that they taught the benefits of healthy eating as part of a required health education course.

b. Food guidance using MyPyramid

Based on 196 responses to this part of the question, 85% of LHETs indicated that they taught MyPyramid as part of a required health education course.

c. Using food labels

Based on 196 responses to this part of the question, 89% of LHETs indicated that they taught using food labels as part of a required health education course.

d. Balancing food intake and physical activity

Based on 194 responses to this part of the question, 95% of LHETs indicated that they taught balancing food intake and physical activity as part of a required health education course.

e. Eating more fruits, vegetables, and grain products

Based on 195 responses to this part of the question, 93% of LHETs indicated that they taught eating fruits, vegetables, and grain products as part of a required health education course.

f. Choosing foods that are low in fat, saturated fat, and cholesterol

Based on 194 responses to this part of the question, 91% of LHETs indicated that they taught choosing foods low in fat, saturated fat, and cholesterol as part of a required health education course.

g. Using sugars in moderation

Based on 195 responses to this part of the question, 88% of LHETs indicated that they taught a moderate use of sugars as part of a required health education course.

h. Using salt and sodium in moderation

Based on 195 responses to this part of the question, 87% of LHETs indicated that they taught a moderate use of salt and sodium as part of a required health education course.

i. Eating more calcium-rich foods

Based on 195 responses to this part of the question, 87% of LHETs indicated that they taught eating more calcium-rich foods as part of a required health education course.

j. Food safety

Based on 197 responses to this part of the question, 78% of LHETs indicated that they taught food safety as part of a required health education course.

k. Preparing healthy meals and snacks

Based on 196 responses to this part of the question, 79% of LHETs indicated that they taught preparing healthy meals and snacks as part of a required health education course.

l. Risks of unhealthy weight control practices

Based on 195 responses to this part of the question, 93% of LHETs indicated that they taught risks of unhealthy weight control practices as part of a required health education course.

m. Accepting body size differences

Based on 194 responses to this part of the question, 86% of LHETs indicated that they taught accepting body size differences as part of a required health education course.

n. Eating disorders

Based on 194 responses to this part of the question, 93% of LHETs indicated that they taught eating disorders as part of a required health education course.

A summary measure for this question on nutrition and dietary topics is the percentage responding "yes" on all parts a-n. Based on 189 responding to all parts, 60% of LHETs indicated they taught *all* of these topics.

Question 11: During this school year, did teachers in this school teach each of the following physical activity topics in a required health education course for students in any of grades 6 through 12? (Mark yes or no for each topic.)

Topic

a. The physical, psychological, or social benefits of physical activity

Based on 194 responses to this part of the question, 95% of LHETs indicated that they taught the various benefits of physical activity as part of a required health education course.

b. Health-related fitness (i.e., cardiovascular endurance, muscular endurance, muscular strength, flexibility, and body composition)

Based on 196 responses to this part of the question, 93% of LHETs indicated that they taught health-related fitness as part of a required health education course.

c. The difference between physical activity, exercise, and fitness

Based on 196 responses to this part of the question, 89% of LHETs indicated that they taught the difference between physical activity, exercise, and fitness as part of a required health education course.

d. Phases of a workout (i.e., warm-up, workout, and cool down)

Based on 197 responses to this part of the question, 82% of LHETs indicated that they taught phases of a workout as part of a required health education course.

e. How much physical activity is enough (i.e., determining frequency, intensity, time, and type of physical activity)

Based on 197 responses to this part of the question, 82% of LHETs indicated that they taught how much physical activity is enough as part of a required health education course.

f. Developing an individualized physical activity plan

Based on 197 responses to this part of the question, 69% of LHETs indicated that they taught developing an individualized physical activity plan as part of a required health education course.

g. Monitoring progress toward reaching goals in an individualized physical activity plan

Based on 197 responses to this part of the question, 65% of LHETs indicated that they taught monitoring progress toward reaching goals in an individualized physical activity plan as part of a required health education course.

h. Overcoming barriers to physical activity

Based on 197 responses to this part of the question, 74% of LHETs indicated that they taught overcoming barriers to physical activity as part of a required health education course.

i. Decreasing sedentary activities such as television watching

Based on 195 responses to this part of the question, 88% of LHETs indicated that they taught decreasing sedentary activities as part of a required health education course.

j. Opportunities for physical activity in the community

Based on 197 responses to this part of the question, 75% of LHETs indicated that they taught about opportunities for physical activity in the community as part of a required health education course.

k. Preventing injury during physical activity

Based on 195 responses to this part of the question, 82% of LHETs indicated that they taught preventing injury during physical activity as part of a required health education course.

l. Weather-related safety (e.g., avoiding heat stroke, hypothermia, and sunburn while physically active)

Based on 195 responses to this part of the question, 82% of LHETs indicated that they taught weather-related safety as part of a required health education course.

m. Dangers of using performance-enhancing drugs, such as steroids

Based on 194 responses to this part of the question, 91% of LHETs indicated that they taught the dangers of using performance-enhancing drugs as part of a required health education course.

A summary measure for this question on physical activity topics is the percentage responding "yes" on all parts a-m. Based on 190 responding to all parts, 50% of LHETs indicated they taught *all* of these topics.

HIV Prevention

Question 12: Are required HIV prevention units or lessons taught in each of the following courses in this school? (Mark yes or no for each course.)

Course

a. Science

Based on 258 responses to this part of the question, 38% of LHETs indicated that they taught HIV prevention units or lessons in science courses.

b. Home economics or family and consumer education

Based on 256 responses to this part of the question, 48% of LHETs indicated that they taught HIV prevention units or lessons in home economics or family and consumer education courses.

c. Physical education

Based on 260 responses to this part of the question, 13% of LHETs indicated that they taught HIV prevention units or lessons in physical education courses.

d. Family life education or life skills

Based on 258 responses to this part of the question, 45% of LHETs indicated that they taught HIV prevention units or lessons in family life education or life skills courses.

e. Special education

Based on 249 responses to this part of the question, 12% of LHETs indicated that they taught HIV prevention units or lessons in special education courses.

f. Social studies

Based on 253 responses to this part of the question, 6% of LHETs indicated that they taught HIV prevention units or lessons in social studies courses.

Collaboration

Question 13: During this school year, have any health education staff worked with each of the following groups on health education activities? (Mark yes or no for each group.)

Group

a. Physical education staff

Based on 274 responses to this part of the question, 64% of LHETs indicated that they worked with physical education staff on health education activities.

b. School health services staff (e.g., nurses)

Based on 273 responses to this part of the question, 70% of LHETs indicated that they worked with school health services staff on health education activities.

c. School mental health or social services staff (e.g., psychologists, counselors, and social workers)

Based on 272 responses to this part of the question, 45% of LHETs indicated that they worked with school mental health or social services staff on health education activities.

d. Nutrition or food service staff

Based on 274 responses to this part of the question, 39% of LHETs indicated that they worked with nutrition or food service staff on health education activities.

Question 14: During this school year, has this school done each of the following activities? (Mark yes or no for each activity.)

Activity

a. Provided families with information on the health education program

Based on 274 responses to this part of the question, 62% of LHETs indicated that they provided families with information on the health education program.

b. Met with a parent's organization such as the PTA to discuss school health education

Based on 273 responses to this part of the question, 17% of LHETs indicated that they met with a parent's organization such as the PTA to discuss school health education.

c. Invited family members to attend health education classes

Based on 275 responses to this part of the question, 22% of LHETs indicated that they invited family members to attend health education classes.

Staff Development

Question 15: During the past two years, did you receive staff development (such as workshops, conferences, continuing education, or any other kind of in-service) on each of the following health education topics? (Mark yes or no for each topic.)

Topic

a. Alcohol or other drug use prevention

Based on 275 responses to this part of the question, 36% of LHETs indicated that they received staff development in the area of alcohol or other drug use prevention, during the past two years.

b. Asthma awareness

Based on 275 responses to this part of the question, 11% of LHETs indicated that they received staff development in the area of asthma awareness, during the past two years.

c. Consumer health, such as choosing sources of health-related information, products, and services wisely

Based on 274 responses to this part of the question, 18% of LHETs indicated that they received staff development in the area of consumer health, during the past two years.

d. Cardiopulmonary resuscitation (CPR)

Based on 275 responses to this part of the question, 51% of LHETs indicated that they received staff development in the area of CPR (cardiopulmonary resuscitation), during the past two years.

e. Dental and oral health

Based on 275 responses to this part of the question, 7% of LHETs indicated that they received staff development in the area of dental and oral health, during the past two years.

f. Emotional and mental health

Based on 275 responses to this part of the question, 25% of LHETs indicated that they received staff development in the area of emotional and mental health, during the past two years.

g. Environmental health, such as how air and water quality can affect health

Based on 274 responses to this part of the question, 11% of LHETs indicated that they received staff development in the area of environmental health, during the past two years.

h. First aid

Based on 274 responses to this part of the question, 42% of LHETs indicated that they received staff development in the area of first aid, during the past two years.

i. Foodborne illness prevention

Based on 275 responses to this part of the question, 21% of LHETs indicated that they received staff development in the area of foodborne illness prevention, during the past two years.

j. Growth and development

Based on 275 responses to this part of the question, 18% of LHETs indicated that they received staff development in the area of growth and development, during the past two years.

k. HIV (human immunodeficiency virus) prevention

Based on 275 responses to this part of the question, 33% of LHETs indicated that they received staff development in the area of HIV prevention, during the past two years.

l. Human sexuality

Based on 274 responses to this part of the question, 18% of LHETs indicated that they received staff development in the area of human sexuality, during the past two years.

m. Immunizations

Based on 275 responses to this part of the question, 21% of LHETs indicated that they received staff development in the area of immunizations, during the past two years.

n. Injury prevention and safety

Based on 274 responses to this part of the question, 26% of LHETs indicated that they received staff development in the area of injury prevention and safety, during the past two years.

o. Nutrition and dietary behavior

Based on 275 responses to this part of the question, 30% of LHETs indicated that they received staff development in the area of nutrition and dietary behavior, during the past two years.

p. Physical activity and fitness

Based on 275 responses to this part of the question, 27% of LHETs indicated that they received staff development in the area of physical activity and fitness, during the past two years.

q. Pregnancy prevention

Based on 275 responses to this part of the question, 15% of LHETs indicated that they received staff development in the area of pregnancy prevention, during the past two years.

r. STD (sexually transmitted disease) prevention

Based on 275 responses to this part of the question, 23% of LHETs indicated that they received staff development in the area of STD prevention, during the past two years.

s. Suicide prevention

Based on 275 responses to this part of the question, 15% of LHETs indicated that they received staff development in the area of suicide prevention, during the past two years.

t. Sun safety or skin cancer prevention

Based on 273 responses to this part of the question, 9% of LHETs indicated that they received staff development in the area of sun safety or skin cancer prevention, during the past two years.

u. Tobacco-use prevention

Based on 274 responses to this part of the question, 17% of LHETs indicated that they received staff development in the area of tobacco-use prevention, during the past two years.

v. Violence prevention (such as bullying, fighting, and homicide)

Based on 275 responses to this part of the question, 47% of LHETs indicated that they received staff development in the area of violence prevention, during the past two years.

Question 16: Would you like to receive staff development on each of these health education topics? (Mark yes or no for each topic.)

Topic

a. Alcohol or other drug use prevention

Based on 268 responses to this part of the question, 60% of LHETs indicated that they would like to receive staff development in the area of alcohol or other drug use prevention.

b. Asthma awareness

Based on 268 responses to this part of the question, 44% of LHETs indicated that they would like to receive staff development in the area of asthma awareness.

c. Consumer health, such as choosing sources of health-related information, products, and services wisely

Based on 266 responses to this part of the question, 42% of LHETs indicated that they would like to receive staff development in the area of consumer health.

d. Cardiopulmonary resuscitation (CPR)

Based on 268 responses to this part of the question, 60% of LHETs indicated that they would like to receive staff development in the area of CPR (cardiopulmonary resuscitation).

e. Dental and oral health

Based on 268 responses to this part of the question, 29% of LHETs indicated that they would like to receive staff development in the area of dental and oral health.

f. Emotional and mental health

Based on 268 responses to this part of the question, 62% of LHETs indicated that they would like to receive staff development in the area of emotional and mental health.

g. Environmental health, such as how air and water quality can affect health

Based on 269 responses to this part of the question, 42% of LHETs indicated that they would like to receive staff development in the area of environmental health.

h. First aid

Based on 268 responses to this part of the question, 57% of LHETs indicated that they would like to receive staff development in the area of first aid.

i. Foodborne illness prevention

Based on 268 responses to this part of the question, 39% of LHETs indicated that they would like to receive staff development in the area of foodborne illness prevention.

j. Growth and development

Based on 268 responses to this part of the question, 46% of LHETs indicated that they would like to receive staff development in the area of growth and development.

k. HIV (human immunodeficiency virus) prevention

Based on 268 responses to this part of the question, 55% of LHETs indicated that they would like to receive staff development in the area of HIV prevention.

l. Human sexuality

Based on 267 responses to this part of the question, 50% of LHETs indicated that they would like to receive staff development in the area of human sexuality.

m. Immunizations

Based on 268 responses to this part of the question, 38% of LHETs indicated that they would like to receive staff development in the area of immunizations.

n. Injury prevention and safety

Based on 268 responses to this part of the question, 48% of LHETs indicated that they would like to receive staff development in the area of injury prevention and safety.

o. Nutrition and dietary behavior

Based on 267 responses to this part of the question, 62% of LHETs indicated that they would like to receive staff development in the area of nutrition and dietary behavior.

p. Physical activity and fitness

Based on 267 responses to this part of the question, 60% of LHETs indicated that they would like to receive staff development in the area of physical activity and fitness.

q. Pregnancy prevention

Based on 267 responses to this part of the question, 52% of LHETs indicated that they would like to receive staff development in the area of pregnancy prevention.

r. STD (sexually transmitted disease) prevention

Based on 268 responses to this part of the question, 54% of LHETs indicated that they would like to receive staff development in the area of STD prevention.

s. Suicide prevention

Based on 269 responses to this part of the question, 69% of LHETs indicated that they would like to receive staff development in the area of suicide prevention.

t. Sun safety or skin cancer prevention

Based on 268 responses to this part of the question, 48% of LHETs indicated that they would like to receive staff development in the area of sun safety or skin cancer prevention.

u. Tobacco-use prevention

Based on 268 responses to this part of the question, 53% of LHETs indicated that they would like to receive staff development in the area of tobacco-use prevention.

v. Violence prevention (such as bullying, fighting, and homicide)

Based on 268 responses to this part of the question, 67% of LHETs indicated that they would like to receive staff development in the area of violence prevention.

Note that *the percentage who would like to receive staff development on these health education topics exceeded the percentage who actually received staff development during the past two years—in every area*. Apparently, these are areas in which health education teachers feel they need more training.

Question 17: During the past two years, did you receive staff development (such as workshops, conferences, continuing education, or any other kind of in-service) on each of the following topics? (Mark yes or no for each teaching topic.)

Topic

a. Teaching students with physical, medical, or cognitive disabilities

Based on 268 responses to this part of the question, 53% of LHETs indicated that they received staff development on teaching students with physical, medical, or cognitive disabilities, during the past two years.

b. Teaching students of various cultural backgrounds

Based on 268 responses to this part of the question, 44% of LHETs indicated that they received staff development on teaching students of various cultural backgrounds, during the past two years.

c. Teaching students with limited English proficiency

Based on 269 responses to this part of the question, 26% of LHETs indicated that they received staff development on teaching students with limited English proficiency, during the past two years.

d. Using interactive teaching methods such as role plays or cooperative group activities

Based on 269 responses to this part of the question, 56% of LHETs indicated that they received staff development on using interactive teaching methods such as role plays or cooperative group activities, during the past two years.

e. Encouraging family or community involvement

Based on 269 responses to this part of the question, 39% of LHETs indicated that they received staff development on encouraging family or community involvement, during the past two years.

f. Teaching skills for behavior change

Based on 267 responses to this part of the question, 50% of LHETs indicated that they received staff development on teaching skills for behavior change, during the past two years.

g. Classroom management techniques, such as social skills training, environmental modification, conflict resolution and mediation, and behavior management

Based on 269 responses to this part of the question, 56% of LHETs indicated that they received staff development on classroom management techniques, during the past two years.

h. Assessing or evaluating students in health education

Based on 268 responses to this part of the question, 21% of LHETs indicated that they received staff development on assessing or evaluating students in health education, during the past two years.

Question 18: Would you like to receive staff development on each of these topics? (Mark yes or no for each teaching topic.)

Topic

a. Teaching students with physical, medical, or cognitive disabilities

Based on 267 responses to this part of the question, 57% of LHETs indicated that they would like to receive staff development on teaching students with physical, medical, or cognitive disabilities.

b. Teaching students of various cultural backgrounds

Based on 266 responses to this part of the question, 47% of LHETs indicated that they would like to receive staff development on teaching students of various cultural backgrounds.

c. Teaching students with limited English proficiency

Based on 267 responses to this part of the question, 43% of LHETs indicated that they would like to receive staff development on teaching students with limited English proficiency.

d. Using interactive teaching methods such as role plays or cooperative group activities

Based on 265 responses to this part of the question, 47% of LHETs indicated that they would like to receive staff development on using interactive teaching methods such as role plays or cooperative group activities.

e. Encouraging family or community involvement

Based on 266 responses to this part of the question, 61% of LHETs indicated that they would like to receive staff development on encouraging family or community involvement.

f. Teaching skills for behavior change

Based on 266 responses to this part of the question, 69% of LHETs indicated that they would like to receive staff development on teaching skills for behavior change.

g. Classroom management techniques, such as social skills training, environmental modification, conflict resolution and mediation, and behavior management

Based on 266 responses to this part of the question, 62% of LHETs indicated that they would like to receive staff development on classroom management techniques.

h. Assessing or evaluating students in health education

Based on 267 responses to this part of the question, 60% of LHETs indicated that they would like to receive staff development on assessing or evaluating students in health education.

Note that *the percentage who would like to receive staff development on these teaching topics exceeded the percentage who actually received staff development during the past two years—in almost every area*. The difference in these percentages was greatest in teaching students with limited English proficiency, encouraging family or community involvement, teaching skills for behavior change, and assessing or evaluating students in health education. Apparently, these are areas in which health education teachers feel they need more training.

Professional Preparation

Question 19: What was the major emphasis of your professional preparation? (Mark one response.)

Of the 244 responding, the combination of health and physical education was the most selected major emphasis (37%), followed by home economics or family/consumer science (21%) and physical education (13%).

Question 20: Currently, are you certified, licensed, or endorsed by the state to teach health education in middle/junior high school or senior high school?

Of the 271 responding, 75% responded in the affirmative. The percentage was higher for high school (81%) and junior/senior high (88%) than for middle school LHETs (60%).

Question 23: Including this school year, how many years have you been teaching health education? (Mark one response.)

Of the 270 responding, 11% had taught one year, 22% two to five years, 15% six to nine years, 15% 10 to 14 years, and 37% had taught 15 years or more.

Discussion and Recommendations

The survey data indicate that health education is being taught in an integrated curriculum in Iowa schools. Health is integrated or taught in conjunction with other subjects and is also sometimes taught via programs or activities outside of a regular classroom. Most lead health education teachers had either (1) health education and physical education or (2) home economics or family/consumer science as the major emphasis of their professional preparation. About two-thirds of lead health education teachers have taught health education for more than five years and more than half of them have taught health education for at least 10 years.

Discussion

In the discussion that follows, we consider three critical areas of health education: (1) HIV and other STDs; (2) violent juvenile crime; and (3) tobacco use.

1. HIV and Other STDs: Policy, Student Behavior, and Preventive Health Education

Forty-three (43) percent of principals responding indicated that their schools have adopted a policy on students or staff with HIV infection or AIDS. This percentage was substantially lower than the percentage on the 2004 SHP (58%) and on the 2002 SHP (65%). The question was changed slightly in 2006 from referring to a "*written* policy that *protects the rights* of students and/or staff with HIV infection or AIDS" to simply a "policy on students and/or staff who have HIV infection or AIDS." Thus, *even though the question was more general in referencing any type of school HIV/AIDS policy, the percentage responding affirmatively declined.*

According to the 2005 Iowa Youth Risk Behavior Survey including 1,359 high school students from across the state, 27% of 9th graders, 37% of 10th graders, 48% of 11th graders, and 65% of 12th graders indicated that they had engaged in sexual intercourse (Veale, 2006a). (See Figure 2.) Slightly less than one-fifth of them indicated that they had four or more sexual partners (in their life) by the 12th grade. These percentages were close to those reported for the nation as a whole (Centers for Disease Control and Prevention, June 9, 2006).

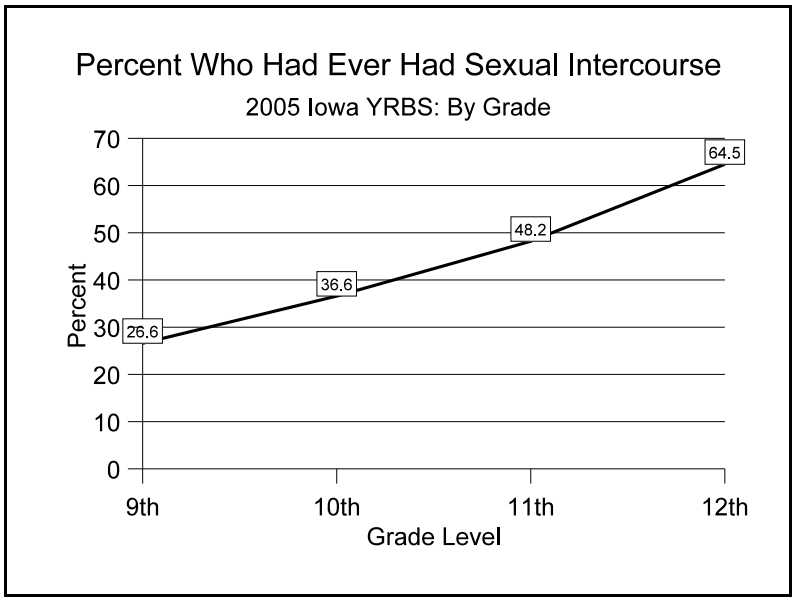

Figure 2: Percent indicating that they had engaged in sexual intercourse. by grade (Veale, 2006a).

Engaging in sexual intercourse, especially if protection is not used, puts students at risk of being infected with HIV and other STDs. *Yet, during their senior year in high school—when reported incidence of sexual intercourse was highest—only 25% of students received required health education (compared with 68% in grades 7 and 8).*

Most lead health education teachers in Iowa (96%) tried to increase student knowledge of HIV prevention in required health education courses. Specifically, 92% taught abstinence as the most effective way to avoid HIV infection and 75% taught condom efficacy, but only 38% taught how to correctly use a condom—as part of required health education. However, accord-

ing to the 2005 Iowa YRBS, 62% of high school students indicated they or their partner had used a condom during their last sexual intercourse (Veale, 2006a).

2. Violent Juvenile Crime and Violence Prevention Activities

Juvenile delinquency, as evidenced by the number of delinquency petitions, has increased in Iowa during the past decade. Teenage gang activity and gang-related crime have also increased in Iowa since the late 1980s. These are *health problems*, as well as social problems.

The challenges to those working in education, health care, juvenile justice, and human services are to (1) develop effective methods for reducing or controlling this problem and (2) ensure the provision of care for its victims. There is evidence from these profiles that at least the first of these challenges is being met in the schools in Iowa. Eighty-two (82) percent of lead health education teachers in Iowa reported that they attempted to improve student knowledge in the area of violence prevention. Moreover, the skill of nonviolent conflict resolution was taught in 84% of schools in Iowa in 2006 and 62% of schools had a program to prevent bullying. Also, there is evidence that many schools in Iowa have put security measures in place, such as requiring visitors to report to the main office or reception area, using staff or adult volunteers to monitor halls, and maintaining a "closed campus." Finally, 97% of principals indicated there was a comprehensive plan for crisis preparedness, response, and recovery in the event of a natural disaster or other emergency situation at their school.

3. Tobacco-Use Policy and Prevention Education

According to the Iowa Department of Education *Iowa Youth Survey*, self-reported cigarette smoking (two or more times per week) increased among Iowa youth from 1981, nearly doubling for students in grades 6, 8, 10, and 12 to 13% overall in 1996 (Governor's Alliance on Substance Abuse, 1997). At the high school level, 22.2% reported smoking cigarettes at least once in the month prior to the 2005 YRBS (down significantly from 37.5% in 1997), while 7.9% reported using smokeless tobacco during this same period (down significantly from 12.8% in 1997) (Veale, 2006a and b).

There is evidence from this profile that schools are making an effort to control, reduce, and prevent tobacco use. It was estimated that nearly all (98%) of principals in secondary schools in Iowa have adopted a policy prohibiting tobacco use. In most cases, this applied to all school buildings, school grounds, school buses, and school events. The most common actions taken when students are caught smoking cigarettes are to (1) refer the student to a school administrator and (2) inform the student's parent(s) or guardian(s) about her/his smoking. Policy specifically prohibiting students from using cigarettes, smokeless tobacco, cigars, and/or pipes was also reported by 95% or more of the principals. Most principals (94% or more) reported that tobacco advertising is prohibited in their schools, as is the wearing of tobacco name-brand apparel and the carrying of tobacco name-brand merchandise (97%). Finally, 60% of principals indicated that their school had posted signs marking a tobacco-free school zone (up from 52% in 2004, 46% in 2002, and 28% in 2000).

In terms of education, it was estimated that 99% of lead health education teachers in Iowa in 2006 tried to increase student knowledge in the area of tobacco use prevention. In addition, more than 90% of these teachers indicated that the following specific tobacco use prevention topics were taught in required health education courses in their schools: short- and long-term consequences of cigarette smoking and use of smokeless tobacco, benefits of not using cigarettes or smokeless tobacco, addictive effects of nicotine, how many young people use tobacco, the influence of families and the media on tobacco use, resisting peer pressure to use tobacco, and the effects of environmental tobacco smoke or second-hand smoke. Fifty-three (53) percent of health education teachers indicated they would like to receive training in tobacco use prevention; only 17% said they had received such training in the past two years.

Recommendations

The first five of the following recommendations concern health education and/or policy, while the last three concern School Health Profile surveys or process.

1. *Encourage additional HIV prevention training or reinforcement of earlier training for juniors and seniors in high school.*

Required health education courses should be delivered to more juniors and seniors, who are most at-risk of HIV infection because of their sexual activity. This should include skills for prevention of HIV and other STDs (e.g., resisting peer pressure and the correct use of condoms) as well as knowledge of HIV prevention (e.g., sexual abstinence, condom efficacy, and the influence of alcohol, recreational, and intravenous drugs on risk for HIV/AIDS).

2. *Encourage the use of a comprehensive HIV prevention policy in all schools in Iowa.*

The apparent decline in the percentage of schools that have a comprehensive HIV prevention policy in place is of concern. In the HIV policy evaluation (Veale, 2005b), the Iowa Department of Education recommended the policy contained in the book *Someone at School has AIDS: A Complete Guide to Education Policies Concerning HIV Infection* (National Association of State Boards of Education, 2001). This sample HIV policy was presented in the HIV policy evaluation report (Veale, 2005b). It should be broadly disseminated and its use encouraged.

3. *Encourage the cooperation and collaboration among the components of the support system for the delivery of health education to students in Iowa schools.*

Components of this system include local entities such as the school administration, parents, adult volunteers (e.g., mentors), community-based agencies, and the business community. Other components might include the Area Education Agency and state and federal government agencies, such as the HIV/AIDS Education Project in Iowa and the CDC. An example of where cooperation and collaboration are needed is the development of school health committees. Sixty (60) percent of schools in Iowa in 2006 had used one or more group(s) (e.g, school health council or committee) for developing policies and coordinating activities regarding health issues, according to school principals. Another example of cooperation and collaboration is in the use of peer educators, reported by 62% of the lead health education teachers in Iowa in 2006. Programs should capitalize on the fact that kids talk to other kids and utilize *positive* peer pressure to change their behavior. Both of the above percentages were higher in 2006 than in previous years, but there is still room for improvement. Collaboration is a key to success in both areas.

4. *Use violence prevention skills training (for students and teachers) more extensively to counter increases in violent juvenile crime and delinquency.*

More emphasis should be given to teaching violence prevention *skills* to increase healthy behaviors among our youth. These include the development of de-escalation, mediation, and conflict resolution skills through role-playing, as well as a planned process for whole school discipline and safety (Dr. Lee Halverson, Consultant at Heartland Area Education Agency, personal communication, November 29, 1995). This should begin at the elementary level or earlier with families of newborn to pre-school age children. An example of such a program is the Drug and Violence Prevention Program at Woodbury Elementary School in Marshalltown, cited by the Iowa Department of Public Health for "best prevention practices" in 1998 and presently in its 11th year of operation (Veale, 2006c and Veale & Morley, 2006). Another example is Community Connections Safe Schools/Healthy Students (CCSS/HS) in Allamakee County, where schools have utilized Olweus Bullying, Character Counts, Success 4, and other instructional incentives for positive student behavior to reduce the number of disciplinary referrals (Veale & Morley, 2006). The latter program/process provides birth-to-graduation services to children, youth, and families in the areas of drug and violence prevention. Both utilize cooperation and collaboration among agencies and other components of the support system in the delivery of these services.

5. *Encourage more staff development in health education content areas, especially violence prevention, tobacco-use prevention, and HIV and other STD prevention.*

As noted in the section on the lead health education teacher survey results, the percentages who would like more staff development in each of the listed health education content areas exceeded those who actually received staff development in the respective areas. The percentage of teachers who indicated they would like staff development in specific content areas was highest for violence prevention. The "gap" between (a) the percentage who would like and (b) the percentage who actually received staff development was high for this and several other areas, including tobacco-use, HIV, and STD prevention. Written comments from several teachers underscored the value of and need for staff development in the health education content areas.

6. *The notion of "required health education course" should be clearly defined or reconsidered in future versions of the SHP.*

Based on written comments from several of the lead health education teachers, there was some confusion about the meaning of the word "required." For example, one teacher stated: "(The term) 'required' needs to be clarified—required by whom? School, teacher, state?" Another pointed out that "Not required does not mean not taught." More than half of the LHET survey questions refer to a "required health education course." This may be excessive. At the very least, a clear definition of what is meant by "required" as applied in these surveys should be included therein.

7. *The surveys should be shortened or combined with others that are conducted periodically by the Departments of Education or Health.*

Administrators and teachers are experiencing greater educational challenges and are being asked to take on additional responsibilities in the education of our youth—often with very limited resources. Either of the above prescriptions should help to secure the continued excellent cooperation of principals and lead health education teachers in providing important information regarding the health education of our youth.

8. *The surveys should be mailed out early in the school year, to provide ample time for principals and health education teachers to complete them*.

This recommendation was based on teacher comments in the 2002 SHP and applied to the 2004 and 2006 SHPs. We trust that this was helpful to respondents and recommend a similarly early mailing of the surveys in 2007-08. We hope that this will help to insure the continued high level of support for these profiles.

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APPENDIX

The School Principal and Lead Health Education Teacher Questionnaires for the 2006 Iowa School Health Profiles